

30 Questions to Rule in Mind/Body Syndrome

(from Freedom From Chronic Pain www.freedomfromchronicpain.com)

Please look at the 30 questions below. The more questions to which you answer 'yes', the more likely it is that Mind/Body Syndrome (MBS) is contributing to your symptoms.

1. Has your doctor completed diagnostic testing without finding a definite cause for your symptom(s)?
2. Do you have more than one symptom? (The more you have, the more likely MBS is involved.)
3. Are your symptoms located in different areas of the body?
4. Are these symptoms different in type? (For example, headache and abdominal bloating.)
5. Did the symptom begin with no obvious trigger or cause?
6. If the symptom began after an injury, has it persisted long after the injury should have healed? (Healing of most physical injury is complete in 6 weeks or less.)
7. Does your symptom move or migrate to different body locations over time?
8. Do your symptoms have the quality of tingling, electric shock, burning, numbness, heat or cold?
9. Are your symptoms more or less intense depending on the time of day, or occur first thing in the morning or in the middle of the night?
10. Do your symptoms occur after, but not during, activity or exercise?
11. Are your symptoms triggered by or increased by stress or thinking about stressful situations?
12. Are your symptoms less severe or less frequent when you are engaged in enjoyable or distracting activities, such as vacation?
13. Are your symptoms less severe or less frequent when you are in an environment that feels safe for you?
14. Are your symptoms less severe or non-existent after physical treatment such as massage, chiropractic, energy work, acupuncture, or after an herbal or vitamin supplement?
15. Are your symptoms triggered by foods, smells, sounds, light, computer screens, menses, changes in the weather or specific movements?
16. Are your symptoms triggered by the anticipation of stress, such as prior to school, work, a doctor's visit, a medical test, a visit to a relative, or a social gathering or during those activities?

17. Are your symptoms triggered by simply imagining engaging in the triggering activity, such as bending over, turning the neck, sitting or standing?
18. Are your symptoms triggered by light touch or gentle stimuli, such as the wind or cold?
19. Did you have adverse experiences in childhood that you would not want a child of your own to have?
20. Would you describe yourself as highly detail-oriented or a perfectionist?
21. Do you care for the needs of so many other people that you have difficulty including yourself among those for whom you care?
22. Is it highly important to you to please others or be seen as good by others?
23. Are you often more critical of yourself than others are?
24. Are people who caused stress for you as a child still active in your life?
25. As an adult, have you been in close relationships with people outside your original family to whom you gave more of yourself than you received in return? Did any of these people place heavy demands on you, try to control you, threaten you or harm you?
26. Did your symptoms begin soon after a terrifying, traumatic or horrifying event or after a triggering event that is linked to a trauma?
27. Over the course of your life, have you had other physical symptoms that your physician struggled to diagnose?
28. In the past or present, have you had an eating disorder (anorexia or bulimia), an addiction (drugs, alcohol, food, sex, work, gambling, shopping, exercise) or engaged in self-cutting behavior?
29. Do you have worry, anxiety or fear out of proportion to any reason to have those?
30. Do you suffer from depression, sleeping difficulty, fatigue, loss of interest in formerly enjoyable activity or thoughts about ending your life? (If so, let your physician know right away.)

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